STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155332	A. BUILDING 00 B. WING	10/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE REHABILITATION & HEALTHCARE CENTEF	281 S CR 200 E CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: September 25, 26, 27, 28, and October 1, 2012 Facility number: 000225 Provider number: 155332 AIM number: 100267670 Survey team: Barbara Gray, RN-TC Sharon Lasher, RN Leslie Parrett, RN (September 25, 26, 27, and October 1, 2012) Angel Tomlinson, RN Census bed type: SNF/NF: 83 Total: 83 Census payor type: Medicare: 10 Medicaid: 58 Other: 15 Total: 83 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on October	F0000	F000 The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or of any violation of regulation.This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a post certification on or after 10-31-2012.We are requesting a desk review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155332	A. BUILDING 00 B. WING	10/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE REHABILITATION & HEALTHCARE CENTEF	281 S CR 200 E CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	9, 2012 by Bev Faulkner, RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155332	A. BUILDING 00 B. WING	10/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE REHABILITATION & HEALTHCARE CENTEF	281 S CR 200 E CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, interview, and record review, the facility failed to provide treatment for depression for 1 of 3 residents reviewed for community discharge. (Resident #72) Findings include: Resident #72's record was reviewed on 9/27/12 at 3:02 P.M. Diagnoses included but were not limited to dementia, weight loss, anxiety, and failure to thrive. An admission Minimum Data Set assessment for Resident #72, dated 7/1/12, indicated the following: Resident Mood Interview - Resident #72 had felt down or depressed, had trouble falling asleep or staying asleep, had felt tired or had little energy, had a poor appetite or was overeating, had felt bad about herself, had trouble concentrating to read or watch television, and had thoughts she would be better off dead or of hurting herself at least one day during the review period.	F0250	F 0250 What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice? On 9/28/12 resident # 72 receivec an order for Zoloft 50mg every day.On 10/02/2012 resident # 72 received an order for Psych Eval and was seen by Harrison Psychological Consultant on 10/03/12.Social Services and Nursing was in-serviced by Linda Lacey RN ED on the following subject matter: theckened liquids, use of body alarms, the need to monitor negative statements and following up on the need for Psych Services.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.All residents have the potential to be affected for PHQ-9 scores of 7 or higher and/or Dx. of depression. All residents have been reviewed using the MDS for the PHQ scores and or Dx. of depression. Those resident's care plans/interventions will be addressed for a PHQ of 7 or above, a Dx. of depression in place to address mood symptoms with interventions, which may include a Psych eval by a	10/31/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155332	A. BUILDING 00 B. WING	10/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE REHABILITATION & HEALTHCARE CENTEF	281 S CR 200 E CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Social Service note for Resident #72, dated 9/11/12 at 2:11 P.M., indicated the following: A Brief Interview for Mental Status (BIMS) and Patient Health Questionnaire-9 (PHQ-9) was completed for Resident #72 on 9/11/12. Her BIMS score was 6 which showed Resident #72 had severe cognition impairment. Her PHQ-9 scored was 17 which showed moderate to severe depression. Resident #72 had indicated she felt depressed all of the time due to being in the facility. She indicated she had little energy all of the time due to feeling bad, had a poor appetite once in awhile, had felt bad about herself all of the time, had trouble sleeping once in awhile, and had thoughts she would be better off dead all of the time. Resident #72 was able to verbalize her wants and needs clearly. She had a care plan in place for her mood, energy, appetite, negative thoughts, and trouble concentrating. Resident #72's BIMS and PHQ-9 had remained the same since her last assessment (8/30/12). Resident #72 took Ativan at bedtime for anxiety and Ativan every 6 hours as needed. Resident #72's would be long term placement at the facility and she was accepting of the plan. A care plan for Resident #72, dated		Psychiatrist/Psychologist, an order for medication, and resident-specific interventions to assist coping adjustments. 10/31/02Social Services and Nursing in-inserviced by Linda Lacey RD ED on follow up scores of 7 or higher, depression and negative statements. 10/09/12.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not reoccur?The IDT team will review clinical records during care plan meeting to ensure all residents with a PHQ of 7 or more/Dx. of depression will have a care plan/intervention developed to address individual psych needs of the resident. Social Service and Nursing in-serviced by Linda Lacey RN, ED on follow up Psych services addressing PHQ scores of 7 or higher, depression and negative statements.How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur, i.e., what quality assurance program will be put into place?To ensure compliance, Social Service is responsible for the completion of the PHQ's and Psych Services CQI tool weekly times four weeks, bi-monthly times 2 months, and then monthly until continued compliance is maintained for 2 consecutive quarters. The CQI committee overseen by the Ed will review the results of these audits. If the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155332	A. BUILDING 00 B. WING	10/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE REHABILITATION & HEALTHCARE CENTEF	281 S CR 200 E CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	7/1/12, indicated the following: Problem-Resident #72 made negative statements e.g. "nothing matters; would rather be dead". Goal-Resident #72 would not harm herself. Approach-Staff would encourage Resident #72 to" verbalize her feelings, concerns, fears, etc... Staff would observed for signs and symptoms of depression (withdrawal, isolation, loss of appetite, etc...)." Staff would work with Resident #72 to identify effective coping mechanism. A care plan for Resident #72, dated 7/1/12, indicated the following: Problem-Resident #72 displayed signs and symptoms of mood distress as evidenced by stating she felt depressed half of the time, had trouble sleeping once in awhile, felt tired all of the time, had a poor appetite once in awhile, felt bad about herself all of the time, and had negative thoughts she would be better of dead all of the time. Resident #72 stated she would never hurt herself. Goal-Resident #72 would verbalize feelings of underlying loss of interest. Approach-Staff would acknowledge to Resident #72 the current situation must be difficult. Staff would explore with the Resident past effective and ineffective coping mechanisms. Staff would identify		threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155332	A. BUILDING 00 B. WING	10/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE REHABILITATION & HEALTHCARE CENTEF	281 S CR 200 E CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	relationships that Resident #72 could draw on. On 9/28/12 at 9:38 A.M., Resident #72 was observed straightening the covers on her bed. Resident #72 indicated she was depressed due to being away from home. "I guess everybody goes through that when they have to leave their home." "It is kind of hard living like this." On 9/28/12 at 1:24 P.M., the Director of Nursing (DoN) indicated Resident #72 had not seen a therapist related to her depression and was not prescribed any medication for depression. The DoN indicated no documentation was available in Resident #72's record the physician had been notified of Resident #72's depression or the physician had addressed her depression. On 10/1/12 at 9:11 A.M., Social Service (SS) #3 indicated the family informed her Resident #72 would voice being depressed at times for attention. SS #3 indicated she had care planned Resident #72's depression. SS #3 indicated she had not taken her concerns about Resident #72's depression to the Interdisciplinary Team meetings. SS #3 indicated she had not informed the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155332	A. BUILDING 00 B. WING	10/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE REHABILITATION & HEALTHCARE CENTEF	281 S CR 200 E CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	physician of Resident #72's repeated concerns related to depression. SS #3 indicated she had not looked at Resident #72's depression as worsening, but now that she looked at it, Resident #72's depression had not worsened but it had not improved. A Social Service Director Position Description provided by the Administrator on 9/28/12 at 2:30 P.M., indicated the following: "Summary of Position Functions-The Social Services Director provides medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Essential Position Functions-Provides assistance to residents in adjusting to the facility".... 3.1-34(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155332	A. BUILDING 00 B. WING	10/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE REHABILITATION & HEALTHCARE CENTEF	281 S CR 200 E CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to follow 1 residents plan of care and physician's order for thickened liquids to prevent aspiration and failed to follow 1 resident's plan of care to utilize a bed alarm, resulting in a fall, for 2 of 24 residents reviewed for care plans and physician orders. (Resident #40 and #96) Findings include: 1.) Resident #40's record was reviewed on 10/1/12 at 10:27 A.M. Diagnoses included but were not limited to Alzheimer's disease with dementia, gastroesophageal reflux disease, and dysphagia (difficulty swallowing). A Care Plan for Resident #40, dated 6/19/12, indicated the following: Problem-Resident #40 required thickened liquids related to dysphagia and was at risk for dehydration. Goal-Resident #40 would be free from signs and symptoms of dehydration. Approach-Staff would	F0282	F-282What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #40 has a physician order stating "may have 1 Mt. Dew daily". Family members in-serviced on signs/symptoms of aspiration due to family request to give resident Mt. Dew when they visit. Nursing staff in-serviced on10/9/12. In-servic done by Linda Lacey RN, ED on material reviewing thickened liquids. Care plan and aides assignment shee updated.NOTE: Resident has not had an episode of aspiration. 9/27/12Resident#96 alarm replaced after nurse did assessment. Nursing staff educated on need to double check alrms. Nursing staff in-serviced by Linda Lacey RN,ED on 10/9/12 on what alarms are used on each resident and the need to double check alarms are appropriately in place. 10/9/12 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Those residents who are on thickened liquids have the potential to be affected by	10/31/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155332	A. BUILDING 00 B. WING	10/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE REHABILITATION & HEALTHCARE CENTEF	281 S CR 200 E CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	monitor Resident #40 for signs and symptoms of dehydration and report to the physician. Staff would offer at least 1440 milliliters of fluid with meals. Staff would offer thickened fluids between meals, with medications, and with snacks. A physician's recapitulation order for Resident #40 for September, 2012, indicated honey thick liquids with a pureed diet, initiated on 7/16/12. On 9/27/12 at 12:05 P.M., Resident #40 was observed being fed a pureed diet with honey thick water and lemonade by CNA #4. Resident #40 was observed drinking a thin liquid, Mountain Dew, from a can with a straw. CNA #4 indicated Resident #40 drank a Mountain Dew daily. On 10/1/12 at 12:49 P.M., the Director of Nursing (DoN) indicated Resident #40 was not care planned to receive a thin liquid Mountain Dew and he did not have a physician's order to receive a thin liquid Mountain Dew. On 10/1/12 at 1:51 P.M., CNA #4 indicated she had given Resident #40 the thin liquid Mountain Dew because his granddaughter had said to give him a can if he was not eating. CNA		deficient practice. All residents on thickened liquids were reviewed for receiving thin liquids. Physician order in place and care plans updated. Aides' assignment sheets update. All residents having alarm devices were reviewed for proper placement. Physician's orders and care plans in place. Aides' assignment sheets updated. Charge nurses make rounds on each shift for placement of alarms and document on TAR. Nursing staff in-serviced by Linda Lacey RN, Ed on material reviewing thickened liquids and alarms.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not reccur?Upon admission and new orders, DNS or Designee will review residents on thickened liquids and alarms. Aides' assignement sheets updated for aide to be aware. The charge nurse to make rounds on each shift to check and document on the TAR that all alarms in place and resident receiving appropriate thickened liquids. Nursing staff in-serviced by Linda Lacey RN, ED on 10/9/12 on placement of alarms and appropriate thickened liquids. Charge nurse to be in-serviced by SDC on 10/26/12 on placement of alarms, thickened liquids, follow-up for Psych services and PHQ of score of 7 or higher to be addressed by Physician. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155332	A. BUILDING 00 B. WING	10/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE REHABILITATION & HEALTHCARE CENTEF	281 S CR 200 E CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	#4 indicated she knew Resident #40 was ordered thickened liquids. 2.) Review of Nursing notes for Resident # 90 on 9/26/12 at 12:20 p.m., indicated on 9/20/12 at 7:40 p.m. "Resident yelling out for help. CNA entered room and resident was observed to be on his knees on fall mat. No injury noted. Resident stated he was trying to get to his wheelchair. Resident placed in wheelchair brought out of room to common area. Neuro checks initiated and WNL(within normal limits). Denies pain/discomfort." On 9/26/12 at 12:32 p.m., review of		SDC will provide in orientation of new nursing staff, training of placement of alarms and use of thickened liquids. 10/31/12How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e, what quality assurance program will be put in place? To ensure compliance, the DNS/Designee is responsible for the completion of the CQI tool (altered fluid consistency) weekly times 4 weeks, bi-monthly 2 months and then monthly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not acheived, an action plan will be developed to ensure compliance. 10/31/12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155332	A. BUILDING 00 B. WING	10/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE REHABILITATION & HEALTHCARE CENTEF	281 S CR 200 E CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Progress notes, dated 9/21/12 at 6:18 p.m., indicated "Fall review for 9/20/12 at 7:40 p.m. Resident found on his knees on his fall mat beside his bed where he had been in bed earlier. Resident stated he was getting up to get into his wheelchair. Alarm was not attached. Staff educated to the need to double check alarms before leaving the room and to ask the resident if he is ready to go to bed before laying down..." Review on 9/27/12 at 10:05 a.m., indicated "Care plan: Problem start date: 7/24/11 Resident is at risk for fall due to dementia and fall history. Goal: Resident will be free from fall related injury thru reviews. Approach start date: 9/20/12 Staff educated to ask resident if he is ready to go to bed. Approach start date: 12/15/11 Pull tab replaced with pressure pad alarm. On 10/1/12 at 12:20 p.m., interview with the DON (Director of Nursing) indicated "The alarm pad was not placed in Resident # 90's bed before he fell." Review of a document on 10/1/12 at 12:30 p.m., provided by the DON			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155332	A. BUILDING 00 B. WING	10/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE REHABILITATION & HEALTHCARE CENTEF	281 S CR 200 E CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	titled "Fall Management Program" dated "Revised 6/12" indicated "Policy: It is the policy of... to ensure residents residing within the facility will maintain maximum physical functioning through the establishment of physical, environmental, and psychosocial guidelines to prevent injury related to falls. PROCEDURE... 4. Charge nurses will communicate the specific care required for each resident to the assigned caregiver on each shift..." 3.1-35(g)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155332	A. BUILDING 00 B. WING	10/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE REHABILITATION & HEALTHCARE CENTEF	281 S CR 200 E CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to provide 1 resident with thickened liquids to prevent aspiration and failed to provide 1 resident with a bed alarm, resulting in a fall, for 2 of 4 residents reviewed for accidents. (Resident #40 and #96) Findings include: 1.) Resident #40's record was reviewed on 10/1/12 at 10:27 A.M. Diagnoses included but were not limited to Alzheimer's disease with dementia, gastroesophageal reflux disease, and dysphagia (difficulty swallowing). A Care Plan for Resident #40, dated 6/19/12, indicated the following: Problem-Resident #40 required thickened liquids related to dysphagia and was at risk for dehydration. Goal-Resident #40 would be free from signs and symptoms of dehydration. Approach-Staff would monitor Resident #40 for signs and	F0323	F323What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 40 has a Physician order for 1 Mt. Dew a day. Family members in-serviced for signs and symptoms of aspiration. Nursing staff in-serviced by Linda Lacey RN, ED on 10/9/12. Material covered on who has thickened liquids, signs/symptoms of aspiration. Aides' assignment sheets updated. Care plan updated. 10/31/12Resdent # 96 alarm replaced after the nurse completed her assessment. Nursing staff educated on need to double check alarms. The charge nurse instructed the staff to check all alarms on other residents for placement. All alarms were in place on the other residents. 9/26/12How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Those residents who have alarms may have the potential of being affected by deficient practices.All residents on thickened liquids were reviewed for receiving thin	10/31/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155332	A. BUILDING 00 B. WING	10/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE REHABILITATION & HEALTHCARE CENTEF	281 S CR 200 E CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	symptoms of dehydration and report to the physician. Staff would offer at least 1440 milliliters of fluid with meals. Staff would offer thickened fluids between meals, with medications, and with snacks. A Speech Therapist Progress and Discharge Summary for Resident #40, dated 7/11/12, indicated the following: Patient/Caregiver training-Staff were educated on Resident #40 not being able to upgrade to a regular diet with thin liquids due to a mechanical soft diet with thick liquids being the safest by mouth intake for Resident #40. A physician's recapitulation order for Resident #40 for September, 2012, indicated honey thick liquids with a pureed diet, initiated on 7/16/12. Resident #40's Minimum Data Set (MDS) Assessment, dated 8/31/12, indicated Resident #40 required extensive assistance of 1 person to eat. Resident #40 coughed or choked during meals or when swallowing medications. A quarterly MDS review progress note for Resident #40, dated 8/31/12 at 3:56 P.M., indicated the following: Resident #40 required a pureed diet		liquids. Physician orders in place and care plans updated as well as the aides' assignment sheets. All residents who have alarm devices were audited for proper placement. Last 90 days of incident reports reviewed. Physician order in place and care plans updated as well as the aides' assignement sheets. Nursing staff in-serviced by Linda Lacey RN, ED on 10/09/12 on thickened liquids and placement of alarms.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.The DNS or Designee will review all orders for thickened liquids and alarms. The charge nurse will monitor and communicate through report to aides which residents on thickened liquids and alarms. Charge nurse to check and document on the TAR all alrms in place and residents receiving appropriate thickened liquids. Nursing staff in-serviced on 10/9/12 by Linda Lacey RN, ED on thickened liquids and placement of alarms. Charge nurses to be in-serviced by SDC on 10/26/12 on thickened liquids and placement of alarms.How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?To ensure compliance, the DNS/Designee is responsible for the ceompletion	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155332	A. BUILDING 00 B. WING	10/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE REHABILITATION & HEALTHCARE CENTEF	281 S CR 200 E CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	with honey thick liquids related to dysphagia. Speech Therapy had treated and attempted to upgrade Resident #40's diet without success. Resident #40 seemed to tolerate his current pureed diet with honey thick liquids well. Fluids were encouraged and offered by staff. Resident #40 continued to cough at times with intake of food or medications. On 9/27/12 at 12:05 P.M., Resident #40 was observed being fed a pureed diet with honey thick water and lemonade by CNA #4. Resident #40 was observed drinking a thin liquid Mountain Dew from a can with a straw. CNA #4 indicated Resident #40 drank a Mountain Dew daily. On 10/1/12 at 12:49 P.M., the Director of Nursing (DoN) indicated Resident #40 was not care planned to receive a thin liquid Mountain Dew and he did not have a physician's order to receive a thin liquid Mountain Dew. The DoN indicated she was not aware Resident #40 had received a thin liquid Mountain Dew. On 10/1/12 at 1:51 P.M., CNA #4 indicated she had given Resident #40 the thin liquid Mountain Dew because his granddaughter had said to give him a can if he was not eating. CNA		of the CQI tool, Residents' Alarm systems/Wanderguards, (attached) weekly tines 4 weeks, bi-monthly times 2 month, and then monthly until continued compliance is maintained for 2 consecutive quarter. The results of these audits will be reviewed by the CQI committee, overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed t ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155332	A. BUILDING 00 B. WING	10/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE REHABILITATION & HEALTHCARE CENTEF	281 S CR 200 E CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	#4 indicated she knew Resident #40 was ordered thickened liquids. A CNA assignment sheet provided by the DoN on 10/1/12 at 2:00 P.M., indicated Resident #40 was to receive honey thickened liquids. 2.) Review of Nursing notes for Resident # 90 on 9/26/12 at 12:20 p.m., indicated on 9/20/12 at 7:40 p.m. "Resident yelling out for help. CNA entered room and resident was observed to be on his knees on fall mat. No injury noted. Resident stated he was trying to get to his wheelchair. Resident placed in wheelchair brought out of room to common area. Neuro checks initiated and WNL(within normal limits). Denies pain/discomfort." On 9/26/12 at 12:32 p.m., review of Progress notes, dated 9/21/12 at 6:18 p.m., indicated "Fall review for 9/20/12 at 7:40 p.m., Resident found on his knees on his fall mat beside his bed where he had been in bed earlier. Resident stated he was getting up to get into his wheelchair. Alarm was not attached. Staff educated to the need to double check alarms before leaving the room and to ask the resident if he is ready to go to bed before laying down. Staff to ask			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155332	A. BUILDING 00 B. WING	10/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE REHABILITATION & HEALTHCARE CENTEF	281 S CR 200 E CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident's wife when he normally went to bed at home. No injuries noted and denies pain. Resident's fall was unwitnessed, neurochecks initiated and WNL. Resident was fully dressed with non-skid socks on. No environmental factors noted to contribute to fall. Glucose was 191 without signs or symptoms of hyperglycemia. Wife and MD has been informed of fall. Alarm was put back in place. Wife states bedtime was around 9 pm at home. Staff will consider a later time for resident to go to bed if agreeable with resident." Review on 9/27/12 at 9:30 a.m. of "Event Report" documentation, dated 9/20/12 at 7:20 a.m., indicated "Describe what Resident was doing prior to fall: Lying in bed. Resident or witness statement of how fall occurred: Trying to get to his wheelchair. What intervention was put into place to prevent another fall. Staff education, ask Resident if he is ready to go to bed. Alarm to be in place before leaving room." Review on 9/27/12 at 10:05 a.m. indicated "Care plan: Problem start date: 7/24/11 Resident is at risk for fall due to dementia and fall history. Goal: Resident will be free from fall			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155332	A. BUILDING 00 B. WING	10/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE REHABILITATION & HEALTHCARE CENTEF	281 S CR 200 E CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	related injury thru reviews. Approach start date: 9/20/12 Staff educated to ask resident if he is ready to go to bed. Approach start date: 6/23/12 Staff to check for needs every 2 hours. Approach start date: 4/10/12 Pressure pad alarm replaced related to non-functioning. Approach start date: 2/27/12 Continue current interventions, successful in preventing injury. Approach start date: 12/28/11 Frequent staff checks while resident in room. Approach start date: 12/15/11 Pull tab replaced with pressure pad alarm. Approach start date: 12/12/11 Fall mat Approach start date: 12/12/11 Low bed with perimeter mattress. Approach start date: 7/24/11 Assist with all mobility and transfers. Approach start date: 7/24/11 Call light in reach with cues to use. Approach start date: 7/24/11 Non skid footwear. Approach start date: 7/24/11 Personal items in reach. Approach start date: 7/24/11 Therapy screen." On 10/1/12 at 10:20 a.m., interview			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155332	A. BUILDING 00 B. WING	10/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE REHABILITATION & HEALTHCARE CENTEF	281 S CR 200 E CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	with CNA # 2 indicated "I always check the chair and bed pad alarm anytime I do care on residents. The nurse checks it every shift and documents she checked it on the treatment form. Resident # 90 uses the chair pad in his bed as well as in his chair." Interview with LPN # 1 on 10/1/12 at 10:40 p.m., indicated "the nurses work 12 hour shifts 7 a.m. to 7 p.m. I usually check the chair and bed alarms while I'm doing med pass or treatments during the first half of the shift. She indicated she has also worked 2nd shift and does the chair and bed alarm checks while they are putting the residents to bed. There is no area on treatment form to document the time the checks were made, just the shift they were done on." On 10/1/12 at 12:20 p.m., interview with DON (Director of Nursing) indicated "batteries are replaced when the function is checked and if it sounds low, staff will replace it. No standardized time to replace them, just when they get low. Staff replace the batteries as needed." The DON indicated "The alarm pad was not placed in Resident # 90's bed before he fell."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155332	A. BUILDING 00 B. WING	10/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE REHABILITATION & HEALTHCARE CENTEF	281 S CR 200 E CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of a document on 10/1/12 at 12:30 p.m., provided by the DON titled "Fall Management Program" dated "Revised 6/12" indicated "Policy: It is the policy of... to ensure residents residing within the facility will maintain maximum physical functioning through the establishment of physical, environmental, and psychosocial guidelines to prevent injury related to falls. PROCEDURE... 4. Charge nurses will communicate the specific care required for each resident to the assigned caregiver on each shift..." 3.1-45(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155332	A. BUILDING 00 B. WING	10/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE REHABILITATION & HEALTHCARE CENTEF	281 S CR 200 E CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. Based on observation, interview, and record review, the facility failed to provide psychiatric services for 1 of 3 residents reviewed for Preadmission Screening and Resident Review (PASRR). (#52) Findings include: Resident #52's record was reviewed on 9/28/12 at 10:46 A.M. Diagnoses included but were not limited to dementia- probable Alzheimer's type, anxiety, depression, and mental retardation. A Psychological Service note for Resident #52, dated 11/8/11, indicated the following: " Reason for review-Assess current levels of aggression and agitation. Recommendations-Continue as is	F0406	F 406What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 52 received an order for Psych Services and was seen by Harrison Psychological Consultation on 10/3/12. Care plan updated. 10/3/12Social Service and Nursing staff in-serviced by Linda Lacey RN, ED on 10/9/12. Material covered on need to have follow-up services be provided on residents coming from a Psych Unit, or have received Psych Services in the past and to monitor PASRR for Level II. 10/9/12How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All residents have the potential to be affected by the deficient practice.All residents were reviewed who was admitted from a Psych Unit or has been on a	10/31/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155332	A. BUILDING 00 B. WING	10/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE REHABILITATION & HEALTHCARE CENTEF	281 S CR 200 E CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	with revaluation in approximately 3 months; consistent with Level 2. Continue with current behavioral protocols." A Social Service Qualified Mental Retardation Professional (QMRP) note for Resident #52, dated 3/2/12, indicated the following: Resident #52 was taking psychiatric medications including Zoloft for depression, trazodone for insomnia, and Seroquel for behaviors. His primary behavioral difficulty was becoming physically aggressive with staff during care. He was also noted to have periods of irritability. His most recent psychiatric service visit was November, 2011. A Developmental Disabilities Service-Individual Support Plan/Case Conference/Review, dated 3/18/12, indicated Resident #52's identified needs included psychiatric services. Resident #52's quarterly Minimum Data Set (MDS) assessment, dated 4/20/12, indicated Resident #52 had no mood or behaviors. Resident #52 significant change MDS assessment, dated 7/20/12, indicated the following: Mood-Resident #52 had a poor appetite or overate in the last 2 to 6 days. Resident #52 began		Psych unit for follow-up services and as needed. All residents have Psych Services ordered unless attending Physician has stated services not needed at this time and families have refused to sign consent form. Upon admission, residents will be reviewed for Level I which may indicate a Level II to be done. For ex: Major Depression and MR/DD. Social Services and Nursing in-serviced by Linda Lacey RN, ED on 10/9/12 on the need to have follow-up Psych and to monitor the need for a Level II to be completed upon admission or within 30 days of admission. 10/31/12Social Services will audit all residents coming from a Psych Unit for appropriate follow-up services using the "PHQ/Psych" CQI form. Upon admission, Social Services will monitor. The IDT team will review clinical records during care plan meeting to ensure all residents have follow-up Psych Services indicated from a Level II or admitted from a Psych Unit. 10/31/12How will the corrective action(s) be monitored to ensure the deficient practice will be recur, i.e, what quality assurance program will be put into place?To ensure compliance, Social Services is responsible for the completion of the PHQs and Psych Services CQI tool weekly times 4 weeks, bi-monthhly times 2 months, and then quarterly until continued compliance is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155332	A. BUILDING 00 B. WING	10/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE REHABILITATION & HEALTHCARE CENTEF	281 S CR 200 E CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	being short tempered and easily annoyed for the last 2 to 6 days. On 9/27/12 at 12:15 P.M., Resident #52 was observed seated in his wheelchair in the dining room. CNA #5 was observed making numerous attempts to get Resident #52 to eat. Resident #52 would turn his head and put his head in his hands. CNA #6 indicated sometimes after staff started feeding him he would begin feeding himself, it depended on his mood. On 10/1/12 at 9:24 A.M., Memory Care Facilitator (MCF) #7 indicated per her phone conversation with one of the psychiatric service staff on 9/28/12, the last time they were in the facility for services, Resident #52 had been out of the building. MCF #7 indicated the psychiatric service staff informed her Resident #52 would be seen on 10/3/12 or no later than the following week. MCF #7 indicated the facility had been having difficulty with residents not being seen by psychiatric services and the facility was in the process of looking into changing service providers due to residents needing more support from the services. MCF #7 indicated she had not been tracking resident's psychiatric visits. MCF #7 indicated		maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155332	A. BUILDING 00 B. WING	10/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE REHABILITATION & HEALTHCARE CENTEF	281 S CR 200 E CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the last time Resident #52 received psychiatric services was in November, 2011. 3.1-23(a) 3.1-23(a)(1) 3.1-23(a)(2)			